1915(c) Home and Community Based Services (HCBS) Waiver Redesign: Service Authorization Webinar

Commonwealth of Kentucky
Cabinet for Health and Family Services
Thursday, October 17, 2019

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Agenda

1. Why Change Service Authorization Method?
2. Service Authorization Purpose Statement
3. Case Manager Roles and Responsibilities
4. Using the Service Authorization Crosswalk
5. Understanding the Cabinet Level Service Authorization Review
6. Changes to Medicaid Waiver Management Application (MWMA)
7. Anticipated Stakeholder Impacts
8. Review of Next Steps

WHY CHANGE SERVICE AUTHORIZATION METHOD?

Decision to Change Service Authorization Method

Why was this needed?

What was decided?

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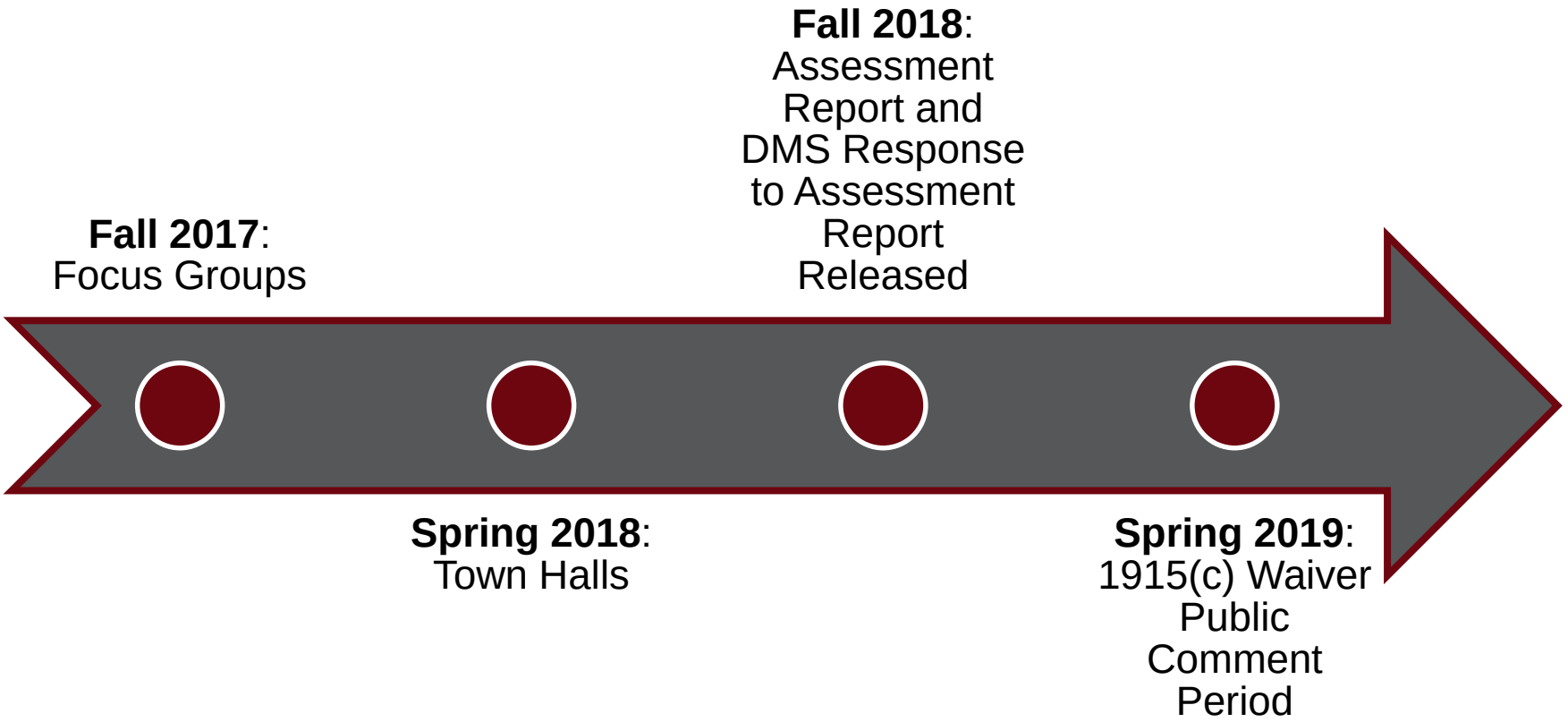
Stakeholder Feedback Informed Changes to the Service Authorization Process



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Authorization Related Stakeholder Feedback

Desire to see services authorized based on the participant's needs, strengths, preferences, identified goals, and desired outcomes

Need for flexible approaches to better allocate services rather than use of a "one size fits all" approach

Concerns regarding the amount of time required to develop a service plan, submit the service plan, and obtain a prior authorization to initiate services

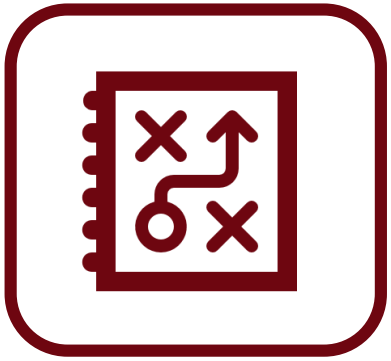
Stakeholder feedback clarified the need for a new service authorization process, incorporating and addressing seven concepts.

Why Was Authorization Change Needed?

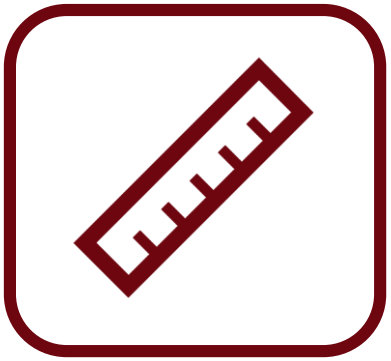
Encourage objective utilization management of HCBS using person-centered, individualized methods that consider a participant's needs and circumstances instead of the current medical model approach

Maximize use of the case manager's first hand insights as the professional with the most "on the ground knowledge" of a participant's functional, social, environmental and behavioral needs

Why Was Authorization Change Needed?

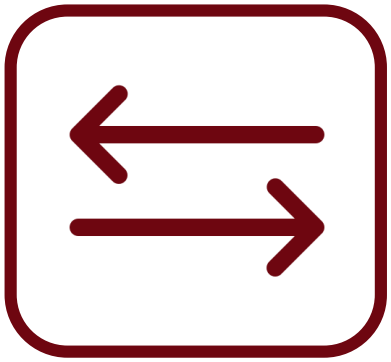


Tackle concerns about over- and under-resourcing of participants Person-Centered Service Plans (PCSPs) based on their assessed needs vs. person-centered plan goals



Reduce waste and misuse of services stemming from “one-size fits all” approaches / methods for service allocation

Why Was Authorization Change Needed?



Apply **consistent methodology and rationale to manage utilization** and drive equity in the scope, amount and duration of services

Reduce the amount of time between PCSP development and service initiation

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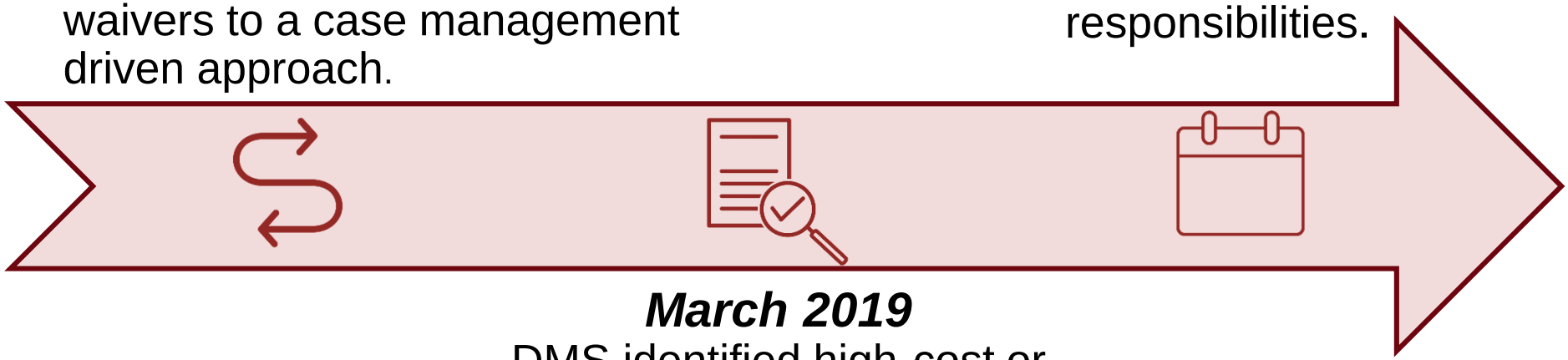
What Service Authorization Decisions Have Been Made?

January 2019
The Department of Medicaid Services (DMS) shifts service authorization for 1915(c) waivers to a case management driven approach.

March 2019
DMS identified high-cost or high-skilled services that will require 100% second-line review by the Cabinet

After 11/22/19
Case Managers will assume primary service authorization responsibilities.



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SERVICE AUTHORIZATION PURPOSE STATEMENT

Service Authorization Purpose Statement

“Person centered thinking is foundational to the development of the PCSP and service authorization. Without it, a plan is more about services than the person. At the same time, **we must responsibly distribute limited resources in a way that promotes equitable access to services for all**…”

- Cabinet for Health and Family Services Purpose Statement, 12/2018

Service authorization provides safeguards so that services are:

Based on participant needs, goals, and desired outcomes	Customized to the individual (service, amount, delivery method, setting)	Promote continuity (Participant wait times and gaps in service are reduced)	Timely, reducing time between PCSP and initial service delivery
Prioritized and accessible to foster participant choice	Appropriate and curb unnecessary over-utilization	Fiscally responsible	Efficient and reduce red tape

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CASE MANAGER ROLES AND RESPONSIBILITIES

What a Case Manager (CM) is Responsible to Do When Authorizing Services

Review Documented Information

- Review participant's functional assessment results, as well as their strengths, preferences, identified goals, and desired outcomes to gain initial understanding of baseline needs and expectations before initiating the PCSP planning process

Consider Documented Needs vs. Participant Requests

- Consider the participant's requested service, amount, scope and duration of services, compared to the participant's documented needs, identified goals, and desired outcomes.
- Identify when participants' service request may be excessive based on the documented needs and explain what the CM is objectively able to authorize in the PCSP.

What a Case Manager (CM) is Responsible to Do When Authorizing Services

Justify Plan of Care Authorized

- Provide information to participant / representative on how the level of need indicated in the assessment influences service authorization

Uphold Participants' Right to Disagree with Authorization

- Provide information to participant / representative on grievance and appeals process provided by DMS to ensure participant receives all needed services

USING THE SERVICE AUTHORIZATION CROSSWALK

Service Authorization Crosswalk

*This **crosswalk** defines each waiver service and determines limitations, efficiencies, and other requirements for service authorization **across all waivers** to provide a summary of current authorization protocols.*

Element	Description
Service	Name of the service
Applicable Waivers	A list of all waivers the service applies to
Summary at a Glance	A brief description of the service and limits
Definition	The service as defined in Appendix C
Limitations	Any limits associated with the service, such as volume limits, conflicts with other services, variation based upon a specific waiver
Duplication of Service Risk	Limitations on this service where it cannot be billed concurrently with another service
DMS Review/Approval	Indication that the service requires approval by DMS or its designee prior to service delivery
Service Indicators	Examples of rationale that support use of the service

Service Authorization Crosswalk-Example

Service Name	**Respite**
Applicable Waivers	**ABI, ABI-LTC**
Summary at a Glance	**Short-term care due to absence or need for relief of a primary caregiver**
Definition	**Respite care service is defined as short term care which is provided to a waiver recipient due to absence or need for relief of the primary caregiver, or provided to an individual who is unable to care for himself during transition from a residential facility. Respite care services must be provided at a level to appropriately and safely meet the medical needs of the waiver recipient. Respite is considered an essential service to assist the recipient and family to prevent institutionalization. The Case Manager or Community Guide shall be responsible for assisting individuals to access other supports or supports available through other available funding streams if their needs exceed the limit.**
Limitations	**ABI: Be limited to 336 hours (1,344 fifteen (15) minute units) per one (1) year authorized person-centered service plan unless an individual's non-paid caregiver is unable to provide care due to a death in the family, serious illness or hospitalization.** **ABI-LTC: Reimbursement for respite care services shall be limited to no more than 5760 fifteen minute units per recipient per calendar year unless an individual's non-paid caregiver is unable to provide care due to a death in the family, serious illness or hospitalization.**
Duplication of service risk	**Yes**
Requires DMS/designee review prior to service delivery	**No**
Service Indicators	**o Provide necessary relief to allow caregivers to take care of personal matters or engage in tasks for other members of the household.** **o Signs/evidence of family/caregiver burnout, including but not limited to:** **- Caregiver lack of self-care** **- Increased agitation between caregiver and participant** **o Caregiver is responsible for 24 hour care of participant**

***Note**: This language is extracted from current KARs and is subject to change.*

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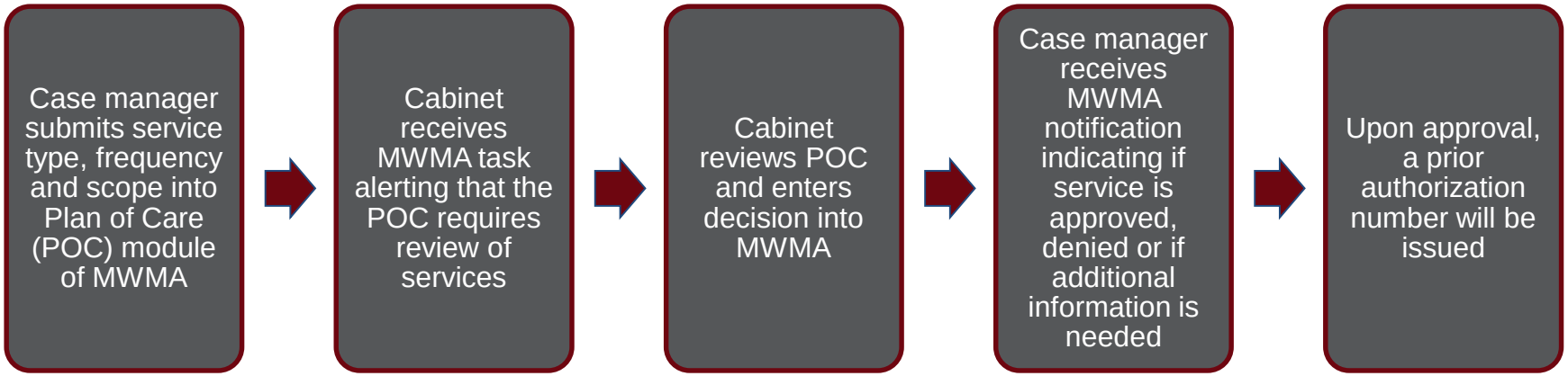
UNDERSTANDING THE CABINET LEVEL SERVICE AUTHORIZATION REVIEW

Cabinet Level Review and Authorization

Cabinet will provide clinical review of high-cost or skilled services. Services must be approved prior to service delivery



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1915(c) Waiver Services Requiring Cabinet Review and Authorization

The Cabinet will:

Use **standard monitoring tools** to promote consistent and objective service authorization reviews

Regularly **review a random selection of participant files** to monitor quality and utilization management across all covered HCBS

The participant's *assessed needs* must support *requested service.*

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1915(c) HCBS Services Requiring Cabinet Review and Authorization

Waiver Service Name	ABI	ABI-LTC	HCB	MPW	SCL	Model II
Behavior Supports				X		
Behavioral Services	X	X				
Consultative Clinical and Therapeutic Services					X	
Counseling	X	X				
Environmental Accessibility Adaptation Services				X	X	
Environmental and Minor Home Adaptation	X	X	X			
Goods and Services	X	X	X	X	X	
Group Counseling	X	X				
Nursing Supports		X				
Occupational Therapy	X	X		X		
Person Centered Coach					X	
Physical Therapy		X		X		
Positive Behavior Supports					X	
Skilled Services by a Licensed Practical Nurse (LPN)						X
Skilled Services by a Registered Nurse (RN)						X
Skilled Services by a Respiratory Therapist (RT)						X
Specialized Medical Equipment	X	X				
Specialized Medical Equipment and Supplies					X	
Specialized Respite			X			
Speech Therapy	X	X		X		
Supported Employment	X	X		X	X	
Vehicle Adaptation					X	

CHANGES TO MEDICAID WAIVER MANAGEMENT APPLICATION (MWMA)

Changes to Medicaid Waiver Management Application (MWMA)

MWMA **updates** will be **deployed on 11/22/2019** and the system will be **available to case managers on 11/25/2019**

Case managers will continue to enter the service type, frequency and scope into the plan of care (POC) module within MWMA

Upon successful service authorization submission, MWMA will interface with the Medicaid Management Information System (MMIS).

MWMA will reflect approval after successful response is received from MMIS.

If the service authorization transaction is not successful, MWMA will return an error message. CMs will need to address entry errors and resubmit the service authorization.

Changes to Medicaid Waiver Management Application (MWMA)

Additional anticipated changes include:

A transition from an external review process to internal for level of care determination and POC review.

Revision of POC processes to accommodate new service review and approval/authorization processes.

The ability to share POC and service information with MMIS.

The ability to transmit program closure information to MMIS through POC screens.

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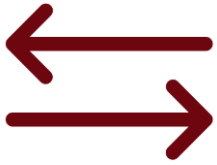
ANTICIPATED STAKEHOLDER IMPACTS

Impact to Participants

With support, participants will continue to lead the person-centered planning process

- Participant will identify the members of the person-centered planning team, which may include family members, friends, community members, and service providers
- Participant will establish goals, desired outcomes, and preferences to drive the participant's PCSP

A participant's level of service may need to be adjusted to align with their assessed level of need.



- CM will assess and reassess resources needed to meet participant's goals, desired outcomes, and preferences
- CM will educate the participant on why their requested service is or is not supported by their assessed need
- DMS will maintain a grievance and appeals process to ensure necessary services remain in PCSPs

Impact to Case Managers

Case Managers will work directly with participants to plan and coordinate services.

- CM will review functional assessment, discuss preferences, outcomes and goals, and obtain participant consent to develop PCSP
- CM will continue to conduct face to face contacts* with participants to monitor utilization and ensure satisfaction

** "Contacts" includes "visits" and "meetings". Please refer to waiver-specific KAR language.*

Additional requirements for case management will be implemented.

- Cabinet will conduct secondary review of skilled and resource-intensive services for plan approval
- Cabinet will complete reviews of random samples of PCSPs to monitor quality and utilization management
- CMs will complete trainings on service authorization changes in early November 2019

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Impact to Case Management Service Providers

Case Management Service Providers are strongly encouraged to provide supervisory review of PCSPs submitted by CM service provider staff.

- Supervisory review should focus on the use of waiver and non-waiver services to ensure all assessed needs are met. This includes frequency of services, amount of services, and appropriateness of goals
- Supervisory review is considered a best practice standard to ensure service appropriateness, help providers identify staff training needs, and protect against risk of fraud, waste, abuse, and adverse monitoring findings

REVIEW OF NEXT STEPS

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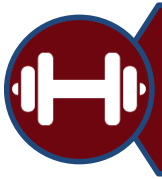
Next Steps



Case managers will be required to complete **service authorization training** in early November 2019**.**

Training will:

- Describe the case management duties related to service authorization
- Review the service definitions and limitations, including use of the service authorization crosswalk
- Provide further instructions on MWMA changes
- Educate CMs on the contents of the service authorization standard operating procedure (SOP)

Next Steps

- Carewise will no longer process prior authorizations for 1915© waiver services as of 11/22/2019
- Case managers will be required to follow the new service authorization process with each new and/or updated person-centered service plan completed
- Pending prior authorizations remaining in queue as of 11/22/19 will transition to the Cabinet for review and approval.

Closing

- Please share information learned today with your colleagues
- Please submit questions and comments to the Cabinet's inbox at: medicaidpubliccomment@ky.gov

Thank you for your time and attention!